

KENTUCKY OFFICE OF WORKERS' CLAIMS
Frankfort, KY 40601**AGREEMENT AS TO COMPENSATION
AND
ORDER APPROVING SETTLEMENT**
Workers' Compensation Claim No. _____**IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.****Every section should be completed. If a section is not applicable, fill in the blank with N/A.**_____
Claimant_____
Insurer/Self-Insured/Self-Insurance Group_____
Social Security Number_____
Date of Birth_____
Insurer's Address_____
Address_____
City, State Zip Code_____
City, State, Zip Code_____
Employer_____
Other participating parties_____
Address_____
Address_____
City, State, Zip Code_____
City, State, Zip Code**HEARING LOSS OR OCCUPATIONAL DISEASE : INJURIOUS EXPOSURE**

Occupational disease: _____ Cause of disease: _____

Date of last exposure: _____ County in which exposure occurred: _____

Brief description of history of exposure: _____

Body part(s) affected: _____ Length of exposure: _____**MEDICAL INFORMATION**

Medical expenses paid: \$ _____ Date of last medical payment: _____

Medical expenses unpaid or contested: \$ _____

Surgery performed: (circle one) Yes No

Nature of surgery: _____

Impairment ratings: (Attach entire medical report that provides ratings)

	Date Given	Physician
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____

Restrictions on activities -- Attach most recent medical report setting forth physical restrictions.

Diagnosis or diagnoses: _____

If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.

WORK INFORMATION

Type of work at last exposure: _____
Average weekly wage at time of last exposure: \$ _____ Date of return to work: _____
Wages upon return to work: \$ _____ Type of work performed after return: _____
Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

If consolidated claims, indicate amount for each claim separately:

Temporary total disability paid from _____ to _____ @ \$ _____ * _____ = \$ _____
(MM/DD/YR) (MM/DD/YR) Amount # of wks Total

Monetary terms of settlement: _____, paid in lump sum: _____, or weekly for _____ weeks

Settlement computation: _____
TTD*IMP RATING*AMA FACTOR*RTW FACTOR*DISC FACTOR OR # OF WKS = TOTAL

Amount for Waiver(s)

Please circle:

Waiver or buyout of past medical benefits	Yes	No	_____
Waiver or buyout of future medical benefits	Yes	No	_____
Waiver of vocational rehabilitation	Yes	No	_____
Waiver of right to reopen	Yes	No	_____

Does settlement include Medicare Set Aside? Yes No If yes, amount of Medicare Set Aside: _____
Lump Sum

Periodic Payments: _____ * _____ * _____ = _____
Amount Frequency Duration Total

Other: Attach explanation

If settlement terms provide for lump sum representing weekly benefits greater than \$100, does claimant have an adequate source of income during disability? Yes No

Source of income: _____ Amount: \$ _____

Does settlement include retraining incentive benefits? Yes No

If yes, is claimant actively participating in instruction or training program? Yes No

Name of instruction or training program (Attach additional pages if necessary): _____

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):

_____ Other
responsible parties against whom further proceedings are reserved: _____

If waiving medical benefits, please acknowledge by signing below:

I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury. _____

Claimant (Signature)

If not represented by an Attorney, please acknowledge by signing below:

I understand that I have a right to obtain an Attorney of my choice to review this Agreement and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney.

Claimant (Signature)

Attorney or representative for claimant (Signature)

Claimant (Signature)

Attorney or representative for claimant (Name typed)

Attorney or representative for employer (Signature)

Address

Address

City, State, Zip

City, State, Zip

Attorney for Special Fund (Div. of Workers' Comp Funds)

This the _____ day of _____, 20____.

DO NOT WRITE OR MARK BELOW THIS LINE

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same is hereby **APPROVED**.

This the _____ day of _____, 20____.

Administrative Law Judge